DIVISION OF HEALTH CARE FINANCING

COORDINATION OF BENEFITS UNIT
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MEDICARE PART B
PROVIDER-BASED BILLING
IMPORTANT (Response required within 120 days)

If a recipient becomes eligible for Medicare on a retroactive basis, the provider is required to submit certain Medicaid-paid claims to Medicare for reimbursement and follow Medicaid's policy regarding submission of crossover claims. The process Wisconsin Medicaid uses to facilitate this is called provider-based billing.

Wisconsin Medicaid has been informed that the recipient(s) identified on the enclosed Provider-Based Billing Summary and claim(s) have Medicare coverage for the dates of service listed. This information was received after Wisconsin Medicaid paid this claim(s).

Since benefits under Wisconsin Medicaid are secondary to those provided by Medicare, providers are required to seek reimbursement from Medicare per HFS 106.03(6) AND (7) Wis. Admin. Code. Providers may not bill recipients for these services.

Return all responses from Medicare within 120 days of the date of the attached summary and include the required supporting documentation (described below) and a copy of the Provider-Based Billing Summary to the following address:

Wisconsin Medicaid
Provider-Based Billing
PO Box 6220
Madison WI 53716-0220

Providers also have the option of faxing the required information to **Medicaid Provider-Based Billing** at **(608) 221-4567**.

If no response is received by Wisconsin Medicaid within 120 days, future payments will be deferred in the amount equivalent to the original Medicaid payment amount for the attached claims. The payment deferral is not considered a final action. Wisconsin Medicaid will accept documentation of Medicare's payment, denial, or non-action after 120 days have elapsed. Therefore, it is not necessary to request a hearing. Refer to the instructions under Section C of this letter for rebilling after a payment deferral has occurred.

SECTION A — SUBMITTING CLAIMS

1. All Providers

Submit the enclosed claims (or providers may produce their own) to Medicare Part B. Ensure that the correct Medicare provider number, Universal Provider Identification Number (UPIN), and Health Insurance Claim (HIC) number (nine digits followed by a one- or two-digit alphanumeric code) are on the claims. Attach any additional documentation required by Medicare.

Note: Providers are required to seek Medicare payment for all dual entitlees (eligible for Medicare and Wisconsin Medicaid) to whom they provide Medicare-covered services. Medicare may retroactively enroll physicians who had valid Wisconsin licenses on the claim date of service.

2. Pharmacies
The National Council for Prescription Drug Programs (NCPDP) electronic claim format only contains one “Other Insurance Indicator” field. If a recipient has both commercial health insurance and Medicare, Wisconsin Medicaid requires that providers reflect the results of billing the commercial carrier in the "other insurance indicator" field. Therefore, if there is both Medicare and commercial drug coverage, it is not apparent to Wisconsin Medicaid whether Medicare was billed.

Provider-based bills are created based on the assumption that Medicare was not previously billed. If Medicare was billed, do not re-bill Medicare. In this case, it is sufficient to provide either a copy or fax of the Medicare Remittance Advice and the Provider-Based Billing Summary page to the applicable address above. If Medicare was not previously billed, bill Medicare, then proceed according to Sections B and C of this letter.

SECTION B — RESPONSES WITHIN 120 DAYS

1. Medicare Payment
When Medicare approves payment, the claim should automatically crossover to Wisconsin Medicaid. The original Medicaid payment should be refunded in full to Wisconsin Medicaid along with a copy of the Medicare Remittance Notice (MRN) and the Provider-Based Billing Summary page. Send this information to the address listed on the previous page.

- Wisconsin Medicaid will create an adjustment to apply the full or partial payment. Do not submit an Adjustment Request form.
- Providers also have the option of sending a refund check along with a copy of the MRN and the Provider-Based Billing Summary page to the address listed on the previous page.

2. Medicare Denial
If Medicare denies payment, send a copy of the MRN and the Provider-Based Billing Summary to the address above.

SECTION C — RESPONSES AFTER 120 DAYS

1. Date of Service within 12 months
Providers should submit a new Medicaid claim through normal processing channels if the date of service is within 12 months and a payment or denial is received from Medicare. Do not use the provider-based billing claim created by Wisconsin Medicaid. Apply the appropriate Medicare disclaimer code. For correct use of Medicare Disclaimer Codes, refer to the Coordination of Benefits section of the Wisconsin Medicaid All-Provider Handbook. (Pharmacies should refer to NCPDP billing guidelines.)

2. Date of Service greater than 12 months
If the date of service is more than 12 months and a payment or denial is received from Medicare, providers may submit a Medicaid claim to the following address:

Wisconsin Medicaid
GR Retro-Eligibility
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Do not use the provider-based billing claim created by Wisconsin Medicaid. Apply the appropriate Medicare disclaimer code. For correct use of Medicare Disclaimer Codes, refer to the Coordination of Benefits section of the Wisconsin Medicaid All-Provider Handbook. (Pharmacies should refer to NCPDP billing guidelines.) In addition, please include documentation of payment or denial (as indicated in Section B, parts 1 and 2 of this letter) and the Provider-Based Billing Summary.

If you have any questions, contact Medicaid Coordination of Benefits at (608) 221-4746, ext. 3142.